A statement by WMADASS in relation to the application to the Supreme Court by the Attorney General for Northern Ireland.

The NI Supreme Court case - Summary

The Supreme Court has been asked by the Northern Ireland Attorney General to consider to consider a point of law. The Supreme Court hears appeals on arguable points of law of the greatest public importance, for the whole of the United Kingdom in civil cases, and for England, Wales and Northern Ireland in criminal cases. The specific question is:

"*Does the Minister of Health for Northern Ireland have the power to revise the Deprivation of Liberty Safeguards Code of Practice ("the Code") so that persons aged 16 and over who lack capacity to make decisions about their care and treatment can give valid consent to their confinement through the expression of their wishes and feelings?*"

Once this case has been heard (20th October 2025), and a judgement published, although originally brought by Northern Ireland, the findings will be relevant to all UK nations. Within England and Wales, this would include the Deprivation of Liberty Safeguards scheme, community deprivations of liberty and any implementation of successor replacement schemes, such as the Liberty Protection Safeguards.

The Attorney General for Northern Ireland considers that the proposed revision to the Code is compatible with the European Convention on Human Rights (ECHR) because it would take persons who lack capacity but can consent to their confinement through the expression of their wishes and feelings outside of the scope of article 5. Further reading on this can be found in the Law Commission "Mental Capacity and Deprivation of Liberty" Law Com No 372 (2014).

If a revision were allowed it would take a different approach to consent from that taken by the Supreme Court in P v Cheshire West and Chester Council and another [2014] UKSC which focussed more on the objective element of a deprivation of liberty and assumed that if the person lacked mental capacity in relation to their care and treatment they could not provide valid consent to a confinement as required by the subjective element.

In Cheshire West, the Supreme Court held that article 5 applies to persons who cannot consent to their confinement because they lack mental capacity. This is the case even where the person who lacks capacity indicates that they are content with the arrangements for their care and treatment.

Background

The concept of deprivation of liberty comes from Article 5 ECHR. Authority for a deprivation of liberty is required in order to comply with Article 5(1) ECHR[1], which places strict limits upon the circumstances under which individuals can be deprived of their liberty.

To fall within the protections of Article 5 three elements must be present, all of which need to be satisfied for the circumstances to be a deprivation of liberty, these are:

1. The **Objective element** -The person is confined to a particular restricted place for a non-negligible period of time (currently described by the 'acid test' from Cheshire West as complete or continuous supervision and control and not free to leave)
2. The **Subjective element** - A lack of valid consent for the confinement. If the person can and does consent, there is no need for further protections.
3. **State Imputability**- The restrictions in place are imputable to the state – in other words the state knew (through direct provision of the service that results in the deprivation of liberty) or ought to have know (because someone informed them of it)

The Deprivation of Liberty Safeguards provides a framework to guard against arbitrary detention for those aged 18 and above who are accommodated in care homes and hospitals. For those in other settings the process is similar, but authorisation is required by the Court of Protection.

For those who are aged under 18 the process is similar but involves a court application unless (for those aged under 16yr) parents are able and willing to use their Parental Responsibility.

The challenge - Implications

The Supreme Court in Cheshire West 2014 focused more on the objective element i.e. the concept of confinement, than the subjective element and this resulted in the 'acid test'.

Since the judgement was published the growth of applications has been exponential in both DoLS and Court applications[2] (note also the lack of a statutory framework for community settings and a lack of clarity about those living 'in their own homes). For DoLS there were 332,455 applications in 2023-24, an increase of 11% on the previous

[1] made part of English law by s.6 Human Rights Act 1998,

[2] Sharp rise in children deprived of their liberty highlights deepening crisis in secure care | Social Work Today

year,[3] compared with Government projections in 2009 of 20,000 annually at the height reducing to 7,000 by 2012.

The argument put forward by NI (as far as we are aware from the available material) is to ask the Supreme Court to consider the subjective element, i.e. whether valid consent can be inferred from a person's wishes and feelings so as to be considered as valid consent.

At its simplest this would mean that where an assessor can determine from a person's expression of wishes and feelings (aged 16 and over) that they are content with the arrangements (even though they lack capacity for care/treatment decisions) this can be assumed to be understood as valid consent to their confinement.

The Attorney General for Northern Ireland considers that the proposed revision to the Code is compatible with the ECHR. It would take those who lack capacity to make decisions about care and treatment but consent to their confinement through the expression of their wishes and feelings, outside of the scope of article 5 (ECHR).

However, the proposed revision would take a different approach to consent to that taken by the Supreme Court in P v Cheshire West and Chester Council and another [2014] UKSC 19. In Cheshire West, the Supreme Court held that article 5 applies to persons who cannot consent to their confinement because they lack mental capacity. This is the case even where the person who lacks capacity indicates that they are content with the arrangements for their care and treatment.

If the Supreme Court finds that there can be "valid" consent to the confinement (expressed by incapacitous wishes or feelings), the outcome in such situations would be that that there is no deprivation of liberty. *Objectively* the way their care and support needed to be delivered may meet the acid test but *subjectively* they could consent to their confinement so no additional process (such as the Deprivation of Liberty Safeguards) would be triggered, although the restrictions will remain.

The potential impact

Backlogs – there were 123,790 assessments of DoLS outstanding at year end 2024. We must consider the impact on these figures if the NI argument succeeds.

The previous Government's Impact Assessment for the Liberty Protection Safeguards estimated that 26% of cases would require the oversight of an Approved Mental Capacity Professional (AMCP) representing those who indicate by their wishes and feelings that they do not agree to the care plan or to their accommodation. This means conversely that 74% do not indicate any issues with, or concerns about, their care/support or accommodation.

[3] Mental Capacity Act 2005, Deprivation of Liberty Safeguards, 2023-24 - NHS England Digital

If the Supreme Court agree that valid consent can be given by the expressed wishes and feelings of a person who lacks capacity to make decisions about their care and treatment, it is possible, therefore, that up to 74% of people could potentially be considered as giving valid consent (clearly some of them may not be indicating either contentment nor disagreement but these figures provide a starting point).

So, based on the 2023/24 published statistics, of the 332,455 requests for DoLS a possible 246,016 (74% of 332, 455) may not trigger Article 5 therefore would not need a DoLS authorisation, leaving around 86,439 annually, requiring a decision on whether an authorisation is needed or not.

NB: This is by no means an exact figure as the annual data does not differentiate between first and subsequent applications for DoLS. Further work could be done to obtain a better analysis but if the Supreme Court agrees that valid consent can be given by the expressed wishes and feelings of a person who lacks capacity to make decisions about their care and treatment, the numbers of authorisations required could significantly reduce. However assessors and experienced professionals will be needed to carry out determinations of this.

Priority – Currently people in this suggested cohort are unlikely to be prioritised (using the ADASS prioritisation tool, or equivalent) for DoLS or community dol applications to Court as they will be among those people who are settled and content and are unlikely to be seen as high priority for assessment. Therefore, if the Supreme Court agrees that valid consent can be given by the expressed wishes and feelings, a methodology would be required to screen this potential cohort from the existing waiting lists. Going forward those who can be understood as giving consent would no longer require the protection of DoLS or community dol orders.

Training and Upskilling the Workforce – Significant multi professional training would be needed on communication and carrying out complex assessments. A broader understanding would be needed on the implications of lacking capacity in relation to decisions about care and treatment but ability to give valid consent to confinement. A new training programme would be needed in council Adult Social Care, hospitals, care homes and wider settings. Much of this would align with work intended to form part of an LPS implementation programme.

Safeguards

Current safeguards

Currently both the DoLS route and the Court route offer safeguards to the person. This is in addition to the fact that the DoLS process and the Court process exist to protect the rights of the person. Even where there is no reduction in restrictions and the care plan remains the same, the person has had independent oversight of their situation.

1. **DoLS scheme** – the person gets a representative known as the Relevant Persons Representative (RPR), who visits regularly and monitors whether the person objects to the arrangements. They and their representative can also have the support of an Independent Mental Capacity Advocate (IMCA) if they wish to challenge the DoLS application. Ultimately the person can challenge the DoLS to the Court of Protection.
2. **Court orders** – the person is appointed a representative throughout the court process and for the period of any authorisation. They can also be joined as a Party to the proceedings. In the case of 16/17 year olds they must always have a full hearing not a paper hearing.
3. **Increased independent oversight -** Because the Cheshire West case brought so many more people into the DoLS scheme, people who would not have had any independent oversight have been seen, by people such as RPRs and IMCAs visiting and although difficult to quantify, for some of them the difference has been significant. People have returned home, restrictive care has been challenged, advocates and representatives have been appointed and safeguarding issues have been noticed and addressed. Additionally, the Court of Protection's insistence that all cases involving under 18yr olds had to have an in-person hearing has meant there has been more opportunity for attention to be given to the risk of restrictive care, and for it to be challenged.

These current safeguards must be seen in the context of significant backlogs, in some areas, which means that many people who may be able to give valid consent potentially have no safeguards currently as they are most likely in the backlog awaiting assessment or an application to Court.

What safeguards would we propose if the Supreme Court decides that valid consent can be given by reference to wishes and feelings

1. **Benefits for People on waiting lists:**
   As stated above, currently the cohort of people who are likely to meet the conditions required for valid consent have the lowest priority for DoLS assessments/Community Dol applications and therefore attract no safeguards whilst they wait. Unfortunately, large numbers of people die waiting for DoLS each year. These are likely to include many people who are very settled in their accommodation. They will be content with the arrangements and by extension, with the care plan. They will not be actively objecting or trying to leave. They will not meet any of the other descriptors currently screened (by the ADASS or similar tool) as high priority.
   So, in fact none of the safeguards are available to them whilst they remain in the backlog or on the waiting list. If they are now able to be screened out of waiting lists and considered by a professional to determine their valid consent, this will

inevitably result in their situation being considered overall. This will require practitioners' time but would still result in a reduction in the waiting list sizes.

2. **Screening tool/statutory guidance**

Many councils currently have had to adopt proportionate measures to attempt to meet the demand of DoLS and community dol applications One of these measures, used on repeat applications, is to screen the person for suitability for a more streamlined assessment. This involves determining if they are settled, the situation is stable, there are no objections etc. We would suggest that a similar screening tool and statutory guidance would be needed to determine those people who may be able to give valid consent by their wishes and feelings.

This would include consideration of

- 'Consent' as more than just a lack of objection.
- The use of direct physical restraint may be a strong indicator that the person is not content with the arrangements.
- A person's behaviour, especially aggression towards staff or other residents or themselves may be a strong indicator that the person may not be content with their arrangements.
- The opinions of others, who don't think the person is content with the arrangements should influence the decision making.

3. **Level of expertise in determining valid consent**

We suggest a further safeguard is that a suitably qualified, independent skilled professional with expertise/experience in ascertaining the person's wishes and feelings, for example a BIA must carry out the assessment or determination of valid consent. There must be measures to avoid conflicts of interests as well as awareness of coercion and control.

4. **Consideration of existing DoLS cases or dol Orders**

Supreme Court agrees that valid consent can be given by expressed wishes and feelings, consideration would need to be given to retrospection in relation to existing DoLS cases, in the Code or in statutory guidance.

There will need to be clarity about reviewing existing DoLS cases and clear guidance to managing authorities, representatives, advocates and friends about new applications (including renewals) both in the event of a relevant change in the person's wishes and feelings, or in the event of the wishes and feelings remaining the same but now being recognised as expressing valid consent.

5. **Advocacy**

Currently under the MCA an Independent Mental Capacity Advocate (IMCA) must be involved in changes of accommodation (arranged by the local authority or NHS) and some of the cohort will fall into this category

An IMCA can also optionally be involved in reviews of a care plan (in both cases where there are no family or friends to consult regarding best interests) which may also be utilised.

The use of an IMCA would be an additional safeguard.

The Care Act and rights to a Care Act advocate will remain in place.

The wider provisions of the MCA, i.e. best interests decision making and welfare applications to the Court of Protection will remain in place.

6. **Additional training for the health and care sector**

Currently DoLS applications are made to the Council by care homes and hospitals (the managing authority). There is a risk with the NI proposal that people who need the protection of DoLS may be screened out inappropriately by managing authorities, resulting in a premature reduction of applications. A training programme would be needed to mitigate this risk. We would urge caution in long-stay hospitals, particularly independent hospitals and situations where a person may be placed outside their local area, but this can be built into a screening tool in statutory guidance.

7. **A Rights-based consideration**

Currently both DoLS and dol orders are seen by some, particularly friends and family of those for whom applications for authorisation have been made, as overly restrictive measures. Families do not always understand their use, especially when people are very happy and settled. Sometimes a person may be living in care home they chose before losing capacity. Some people are experiencing excellent person centred care and living a life with as much autonomy as they can but still require a DoLS authorisation or dol Order.

Removing the need to be subject to external scrutiny and oversight can be both positive and negative. The MCA has twin aims of empowerment and protection. DoLS usually operates as protection, but it can be equally empowering for someone to know that their wishes and feelings have been heard. This paves a way for supported decision making to provide evidence of the person's wishes and feelings in relation to their accommodation even though they may not have the mental capacity to make decisions about their care and treatment.

Conclusion and recommendations

The NI Supreme Court case offers an opportunity to think again about Cheshire West and the operational deluge of applications both for Councils and the Court which followed.

We recommend that ADASS/LGA/BASW supports in principle a process where an examination of the subjective element presents the opportunity for people to consent to their confinement (subject to safeguards) and to embed the MCA principles more widely.

Currently much of the work in relation to deprivation of liberty is carried out by specific professionals, mainly Best Interests Assessors and s12 Approved Mental Health Assessors (MHA). The LPS proposals aimed to make this work and MCA practice much more mainstream. If the NI proposals are adopted it would require improved excellence in assessment by a wider group of practitioners and a need to ensure robust practice in terms of existing safeguards such as timely Care Act needs assessments and reviews and robust legal literacy for all staff.

In summary and subject to subject to robust independent safeguards, ideally underpinned by statutory provisions and guidance we cautiously support the position that a person can lack capacity to make decisions about their care and treatment but be able to provide valid consent to their confinement through the expression of their wishes and feelings.